

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-027810

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 121

FILED JUL 18 1962

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Randolph</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Macon</u>		c. CITY OR TOWN <u>Jacksonville</u>	
Length of stay in 1b <u>10 Days</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Samuelson Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>RFD #1</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OSCAR OSWALD LOWRY</u>		4. DATE OF DEATH Month Day Year <u>July - 9 - 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & Salesman</u>		11. BIRTHPLACE (City and state of country) <u>Monroe Co. Mo.</u>	
13a. FATHER'S NAME <u>Arch O. Lowry</u>		14. NAME OF HUSBAND OR WIFE <u>Leta Lowry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		17. INFORMANT <u>Mrs. Leta Lowry</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitigated abdominal carcinoma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Primary Adenocarcinoma of Ovary</u> DUE TO (c) <u>Operated in 1959</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>June 15, 1962</u> to <u>July 9, 1962</u> and last saw her alive on <u>July 9, 1962</u> Death occurred at <u>130 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James E. Campbell, M.D.</u>		22b. ADDRESS <u>Macon, Mo</u>	
22c. DATE SIGNED <u>7/13/62</u>		22d. LOCATION (City, town, or county) <u>Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July - 11 - 62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Garden</u>	23d. LOCATION (City, town, or county) <u>Mo</u>
24. FUNERAL DIRECTOR <u>Carter Funeral Home</u>	25. DATE RECD. BY LOCAL REG. <u>7-13-62</u>	26. REGISTRAR'S SIGNATURE <u>Patricia Reedy</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

1 0611
2 0880
3 1
4 0
5 1
6
7 0
8 0
9 153.0
10
11
12 1-0
13 1-0

JUL 20 1962

MAR 13 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

R. M. Carter

Licensed Embalmer No. _____

4117

P. O. Address _____

Moherly Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.